Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL GUIDELINE CLEARINGHOUSE

General

Guideline Title

Occupational therapy practice guidelines for adults with Alzheimer's disease and related major neurocognitive disorders.

Bibliographic Source(s)

Piersol CV, Jensen L. Occupational therapy practice guidelines for adults with Alzheimer's disease and related major neurocognitive disorders. Bethesda (MD): American Occupational Therapy Association, Inc. (AOTA); 2017. 45 p. [295 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Schaber P. Occupational therapy practice guidelines for adults with Alzheimer's disease and related disorders. Bethesda (MD): American Occupational Therapy Association, Inc.; 2010. 198 p. [279 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

NEATS Assessment

National Guideline Clearinghouse (NGC) has assessed this guideline's adherence to standards of trustworthiness, derived from the Institute of Medicine's report Clinical Practice Guidelines We Can Trust.

= Poor = Fair = Good = Very Good = Excellent

Assessment	Standard of Trustworthiness
YES	Disclosure of Guideline Funding Source
	Disclosure and Management of Financial Conflict of Interests

	Guideline Development Group Composition
UNKNOWN	Multidisciplinary Group
YES	Methodologist Involvement
▮▮▮▮▯	Patient and Public Perspectives
	Use of a Systematic Review of Evidence
▮▮▮▮▯	Search Strategy
▮▮▮▮▯	Study Selection
▮▮▮▮▮	Synthesis of Evidence
	Evidence Foundations for and Rating Strength of Recommendations
▮▮▮▮▯	Grading the Quality or Strength of Evidence
▮▮▮▮▮	Benefits and Harms of Recommendations
▮▮▮▮▮	Evidence Summary Supporting Recommendations
▮▮▮▮▮	Rating the Strength of Recommendations
▮▮▯▯▯	Specific and Unambiguous Articulation of Recommendations
▮▯▯▯▯	External Review
▮▮▮▯▯	Updating

Recommendations

Major Recommendations

Note from the National Guideline Clearinghouse (NGC): In addition to the evidence-based recommendations below, the guideline includes extensive information on the evaluation process and intervention strategies for adults with Alzheimer's disease and related major neurocognitive disorders (NCDs).

Definitions for the strength of recommendations (A–D, I) and levels of evidence (I–V) are provided at the end of the "Major Recommendations" field.

Recommendations for Occupational Therapy Interventions for People with Major NCDs and Their Caregivers

Interventions Designed to Establish, Modify, and Maintain Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), Leisure, and Social Participation

> ADL training or activity modification to improve or maintain ADL and leisure performance (A)
> Exercise-based interventions (e.g., endurance, balance, resistance training) for improving or maintaining ADLs, including functional mobility and sleep (A)

Errorless learning and prompting strategies to improve ADL performance (A)
Cognitive stimulation for enhanced social participation (A)
Montessori methods for enhanced performance in self-feeding (B)
Spaced retrieval techniques for improved self-feeding (B)
Individualized social activities to enhance sleep (B)
Multicomponent interventions for improving or maintaining quality of life (QOL) (B)
Multicomponent interventions for increasing activity variety and physical function (C)
Comprehensive rehabilitation to improve QOL (C)
Cognitive training (i.e., practice of discrete cognitive tasks) and cognitive rehabilitation (i.e., strategy-based training for cognitive tasks) for improved occupational performance (I)
Multicomponent intervention to improve or maintain ADL performance (I)
Reminiscence therapy for improved ADL performance (I)
Occupation-based interventions for reducing problematic behaviors (C)
Sleep education to improve sleep performance (I)
Yoga for enhanced ADL performance (I)
Comprehensive rehabilitation to improve ADLs (I)
Dosage for exercise-based interventions to improve or maintain ADLs (I)
A variety of other interventions, including use of music, gardening, environmental modification, and outdoor activities, among others, for improving and maintaining occupational performance (I)
Cognitive stimulation for ADL maintenance or improvement (D)

Environment-based Interventions to Improve Behavior and Perception and to Reduce Falls

Person-centered, individually tailored environment-based interventions for improving behavior during the duration of the intervention (A)
Rooms designed for the intended purpose (i.e., privacy and personalization of resident bedrooms and familiar ambiance for living rooms and dining rooms) to improve behaviors (A)
Monitoring devices for fall prevention used in the home (A)
Environmental interventions to compensate for perceptual changes rather than to change perceptual abilities (A)
Ambient music for improving behavior at times other than mealtimes (A)
Multisensory interventions (e.g., Snoezelen®) for short-term behavior improvements (A)
Concealed or painted doorknobs, murals on doors, or blinds or cloth barriers over doors to reduce exit attempts (B)
Environmental design principles of murals and other art on walls, L-shaped corridors, and good visual access to important amenities (e.g., the toilet) for reducing disorientation and promoting engagement (B)
Environmental noise-level regulation to a moderate level for improving behavior (B)
Environmental relocation (e.g., moving residents from a traditional nursing unit to a special care unit (SCU) with no negative long-term effects on behavior (B)
Signage, personal memorabilia, and other environmental cues (e.g., colors, numbers) to facilitate way finding (C)
Aromatherapy to improve behavior (C)
Monitoring devices for fall prevention in institutional settings (C)
Ambient music to improve behavior during mealtimes (I)
Bright light therapy to decrease behavioral disturbances (I)
Proprioceptive sensory input (i.e., air mat therapy) to improve behavior (I)
Functional task object availability in the environment to improve behavior (I)
SCUs and other homelike environments assumed to be superior to traditional nursing homes for improving overall behavior (I)
Wander gardens for improving behavior and reducing falls (I)
Black tape grids or stripes on floor in front of doors to reduce exit attempts (I)
Sensory devices worn by people with mild Alzheimer's disease (AD) to facilitate way finding (I)
Tinted lenses, prisms, and other optical devices for improving perception (I)
Environmental modification without other concurrent fall-reduction strategies for preventing falls (I)

Ambient music for reducing falls (D)
Multisensory interventions (e.g., Snoezelen) for long-term behavior improvements (D)

Educational and Supportive Strategies for Caregivers to Maintain Participation in That Role

Multicomponent psychoeducational interventions for improved caregiver QOL, well-being, confidence, perception of burden, mental health, and self-efficacy (A)
Communication skills training, either alone or in combination with memory aid training, for caregiver QOL and well-being (A)
Cognitive reframing therapy for reducing caregiver anxiety, depression, and stress (A)
Mindfulness and stress reduction interventions, live or virtually, for improved caregiver mental health (A)
Professionally led support groups for enhanced caregiver well-being and QOL (A)
Multicomponent psychoeducational interventions for delayed nursing home placement (B)
Case management by occupational therapy practitioners focused on both the client and the caregiver for promoting caregiver respite access (B)
Family- or peer-led support groups for increasing QOL (B)
Physical activity and exercise program, in person and by telephone, for reduction in caregiver stress (B)
Cognitive-behavioral therapy (CBT) caregiver interventions for practitioner–caregiver interaction for positive caregiver outcomes (B)
Web-based support groups for caregiver well-being and QOL (C)
Training in use of assistive devices to promote device use (C)
Professionally led support group for enhanced caregiver competence (I)
Evidence-based program (Skills$_2$Care) successfully delivered by home-based occupational therapists and reimbursed by Medicare Part B (I)
CBT delivered in person or by telephone to reduce caregiver depression and burden (I)
Leisure routines shared between client and caregiver to improve caregiver well-being (I)
Caregiver counseling involving family meetings for preventing caregiver depression and anxiety (D)
Home monitoring systems to reduce caregiver worry and improve caregiver sleep (D)

Definitions

Strength of Recommendations

A–There is strong evidence that occupational therapy practitioners should routinely provide the intervention to eligible clients. Good evidence was found that the intervention improves important outcomes and concludes that benefits substantially outweigh harm.

B–There is moderate evidence that occupational therapy practitioners should routinely provide the intervention to eligible clients. There is high certainty that the net benefit is moderate, or there is moderate certainty that the net benefit is moderate to substantial.

C–There is weak evidence that the intervention can improve outcomes. It is recommended that the intervention be provided selectively on the basis of professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.

I–There is insufficient evidence to determine whether or not occupational therapy practitioners should be routinely providing the intervention. Evidence that the intervention is effective is lacking, of poor quality, or conflicting and the balance of benefits and harm cannot be determined.

D–It is recommended that occupational therapy practitioners do not provide the intervention to eligible clients. At least fair evidence was found that the intervention is ineffective or that harm outweighs benefits.

Note: Criteria for level of evidence and recommendations (A, B, C, I, D) are based on standard language from the U.S. Preventive Services Task Force (2016). Suggested recommendations are based on the available evidence and content experts' clinical expertise regarding the value of using such evidence.

Levels of Evidence for Occupational Therapy Outcomes Research

Levels of Evidence	Definition
Level I	Systematic reviews, meta-analyses, and randomized, controlled trials
Level II	Two groups, nonrandomized studies (e.g., cohort, case control)
Level III	One group, nonrandomized (e.g., before-after, pretest and posttest)
Level IV	Descriptive studies that include analysis of outcomes (e.g., single-subject design, case series)
Level V	Case reports and expert opinions, which include narrative literature reviews and consensus statements

Note: Adapted from "Evidence-based medicine: What it is and what it isn't." D. L. Sackett, W. M. Rosenberg, J. A. Muir Gray, R. B. Haynes, & W. S. Richardson, 1996, *British Medical Journal, 312*, pp. 71-72.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Alzheimer's disease and related major neurocognitive disorders

Note: Causes of major neurocognitive disorders (NCD), aside from AD, include frontotemporal lobar degeneration, Lewy body disease, vascular disease, traumatic brain injury, substance or medication use, HIV infection, prion disease, Parkinson's disease, Huntington's disease, NCD resulting from another medical condition, NCD with multiple etiologies, and unspecified NCD.

Guideline Category

Counseling

Evaluation

Management

Prevention

Rehabilitation

Clinical Specialty

Family Practice

Geriatrics

Internal Medicine

Neurology

Nursing

Physical Medicine and Rehabilitation

Preventive Medicine

Psychiatry

Psychology

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Health Care Providers

Health Plans

Hospitals

Managed Care Organizations

Nurses

Occupational Therapists

Other

Physical Therapists

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Social Workers

Utilization Management

Guideline Objective(s)

- To provide an overview of occupational therapy interventions for people with major neurocognitive disorders (NCDs) on the basis of existing evidence of the effects of various interventions
- To help guide future decisions for research by highlighting areas in which promising interventions lack enough evidence of a clear benefit or in which available interventions fail to meet specific needs of clients with major NCD
- To be useful to many involved in providing services to people with major NCD, such as occupational therapy practitioners and educators, team members, clients, families, caregivers, third party payers, and policymakers

Target Population

Adults with Alzheimer's disease and related major neurocognitive disorders and their caregivers

Interventions and Practices Considered

1. Interventions designed to establish, modify, and maintain activities of daily living (ADLs), instrumental activities of daily living (IADLs), leisure, and social participation
2. Environment-based interventions to improve behavior and perception and to reduce falls

3. Educational and supportive strategies for caregivers to maintain participation in that role

Major Outcomes Considered

Effectiveness of interventions on:

Activities of daily living (ADLs) and instrumental activities of daily living (IADLs)
Social and leisure participation
Behavior, perception, and falls in both the home and other settings
Caregiver ability to maintain role

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Three focused questions framed the review of occupational therapy interventions for people with Alzheimer's disease (AD) and related major neurocognitive disorders (NCDs).

What is the evidence for the effectiveness of interventions designed to establish, modify, and maintain occupations (activities of daily living, instrumental activities of daily living, leisure, and social participation) for people with AD and related major NCDs?
What is the evidence for the effectiveness of environment-based interventions on behavior, perception, and falls in both the home and other settings (e.g., long-term care, assisted living) for people with AD and related major NCDs?
What is the evidence for the effectiveness of educational and supportive strategies for caregivers of people with AD and related major NCDs on the ability to maintain participation in that role?

Methodology

Search terms for the reviews were developed by the methodology consultant to the American Occupational Therapy Association (AOTA) Evidence-Based Practice (EBP) Project and AOTA staff, in consultation with the review authors of each question, and by the advisory group. The search terms were developed not only to capture pertinent articles but also to make sure that the terms relevant to the specific thesaurus of each database were included. The original search strategy for the focused questions on AD and related major NCDs was used for the updated review. Additional search terms were added to ensure maximum coverage of those questions.

Table F.1 in the original guideline document lists the search terms related to population (AD and related major NCDs) and types of interventions included in each systematic review. A medical research librarian with experience in completing systematic review searches conducted all searches and confirmed and improved the search strategies.

Databases and sites searched included MEDLINE, PsycINFO, CINAHL, and OTseeker. In addition, consolidated information sources, such as the Cochrane Database of Systematic Reviews, were included in the search. These databases are peer-reviewed summaries of journal articles and provide a system for clinicians and scientists to conduct systematic reviews of selected clinical questions and topics. Moreover,

reference lists from articles included in the systematic reviews were examined for potential articles, and selected journals were hand searched to ensure that all appropriate articles were included.

Inclusion and exclusion criteria are critical to the systematic review process because they provide the structure for the quality, type, and years of publication of the literature that is incorporated into a review. The review of all three questions was limited to peer-reviewed scientific literature published in English. The intervention approaches examined were within the scope of practice of occupational therapy. The literature included in the review was published between 2006 and April 2014 and included study participants with AD and related major NCDs. The review excluded data from presentations, conference proceedings, non–peer-reviewed research literature, dissertations, and theses. Studies included in the review are Level I, II, and III evidence. Level IV and V evidence was included only when higher level evidence on a given topic was not found.

A total of 6,927 citations and abstracts were included in the reviews. For the question on occupation-based interventions, there were 2,597 references; for the question on environment-based interventions, there were 1,854 references; and for the caregiver question, there were 2,476 references. The consultant to the EBP Project completed the first step of eliminating references on the basis of citation and abstract. The systematic reviews were carried out as academic partnerships in which academic faculty worked either as faculty pairs or with graduate students. Review teams completed the next step of eliminating references on the basis of citations and abstracts. The full-text versions of potential articles were retrieved, and the review teams determined final inclusion in the review on the basis of predetermined inclusion and exclusion criteria.

Number of Source Documents

A total of 137 articles were included in the final review.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence for Occupational Therapy Outcomes Research

Levels of Evidence	Definition
Level I	Systematic reviews, meta-analyses, and randomized, controlled trials
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Level V	Case reports and expert opinions, which include narrative literature reviews and consensus statements

Note: Adapted from "Evidence-based medicine: What it is and what it isn't." D. L. Sackett, W. M. Rosenberg, J. A. Muir Gray, R. B. Haynes, & W. S. Richardson, 1996, *British Medical Journal, 312*, pp. 71-72.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

The teams working on each focused question reviewed the articles according to their quality (scientific rigor and lack of bias) and levels of evidence. Each article included in the review was then abstracted using an evidence table that provides a summary of the methods and findings of each article. American Occupational Therapy Association (AOTA) staff and the Evidence-Based Practice (EBP) Project consultant reviewed the evidence tables to ensure quality control. All studies are summarized in full in the evidence tables in Appendix G in the original guideline document. The risk of bias of individual studies was assessed using the methods described by Higgins, Altman, and Sterne (2011). The method for assessing the risk of bias of systematic reviews was based on the measurement tool developed by Shea et al. (2007). Risk of Bias tables are included in Appendix G in the original guideline document.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

A major focus of the American Occupational Therapy Association, Inc. (AOTA's) Evidence-Based Practice (EBP) projects is an ongoing program of systematic review of the multidisciplinary scientific literature, using focused questions and standardized procedures to identify occupational therapy–relevant evidence and discuss its implications for practice, education, and research. An evidence-based perspective is founded on the assumption that scientific evidence of the effectiveness of occupational therapy intervention can be judged to be more or less strong and valid according to a hierarchy of research designs, an assessment of the quality of the research, or both.

AOTA uses standards of evidence modeled on those developed in evidence-based medicine. This model standardizes and ranks the value of scientific evidence for biomedical practice using a grading system presented in the "Rating Scheme for the Strength of the Evidence" field. In this system, the highest level of evidence, Level I, includes systematic reviews of the literature, meta-analyses, and randomized controlled trials (RCTs). In RCTs, participants are randomly allocated to either an intervention or a control group, and the outcomes of both groups are compared. Other levels of evidence include Level II studies, in which assignment to a treatment or a control group is not randomized (cohort study); Level III studies, which do not have a control group; Level IV studies, which use a single-case experimental design, sometimes reported over several participants; and Level V studies, which are case reports and expert opinions that include narrative literature reviews and consensus statements.

The systematic reviews on Alzheimer's disease (AD) and related major neurocognitive disorders (NCDs) were supported by AOTA as part of the EBP Project. AOTA is committed to supporting the role of occupational therapy in this important area of practice. This guideline was commissioned, edited and endorsed by AOTA without external funding being sought or obtained. The report was entirely supported financially by AOTA and was developed without any involvement of industry. A previous review covered the time frame of 1994–2005. The current systematic reviews were updated for the period 2006–April 2014. These reviews are crucial because occupational therapy practitioners need access to the results of the latest and best available literature to support intervention for people with AD and related major NCDs within the scope of occupational therapy practice.

Three focused questions framed the review of occupational therapy interventions for people with AD and related major NCDs. These questions were reviewed by the review authors, an advisory group of experts in the field (occupational therapists and an applied research sociologist), AOTA staff, and the methodology consultant to the AOTA EBP Project.

Rating Scheme for the Strength of the Recommendations

Strength of Recommendations

A–There is strong evidence that occupational therapy practitioners should routinely provide the intervention to eligible clients. Good evidence was found that the intervention improves important outcomes and concludes that benefits substantially outweigh harm.

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Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

Peer Review

Description of Method of Guideline Validation

This practice guideline was reviewed by a group of content experts on people with Alzheimer's disease (AD) and related major neurocognitive disorders (NCDs) that included a consumer representative and policy experts.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

The final review included 137 articles. The table below provides a breakdown of the number of studies included in the complete review by level of evidence.

Table. Number and Levels of Evidence for Articles Included in Each Review Question

Number of Articles Included in Review						
Review Question	**Level I**	**Level II**	**Level III**	**Level IV**	**Level V**	**Total in Each Review**

Number of Articles Included in Review						
Review Question	Level I	Level II	Level III	Level IV	Level V	Total in Each Review
Occupation	27	15	10	0	0	52
Environment	22	4	16	0	0	42
Caregiver	28	7	8	0	0	43
Total	77	26	34	0	0	137

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

This guideline may be used to assist:

Occupational therapists and occupational therapy assistants in providing evidence-based interventions for adults with Alzheimer's disease (AD) and related major neurocognitive disorders (NCDs) and their caregivers
Occupational therapists and occupational therapy assistants in communicating about their services to external audience
Other health care practitioners, case managers, clients, families and caregivers, and health care facility managers in determining whether referral for occupational therapy services is appropriate
Third-party payers in determining the medical necessity for occupational therapy
Legislators; third-party payers; federal, state, and local agencies; and administrators in understanding the professional education, training, and skills of occupational therapists and occupational therapy assistants
Health and social services planning teams in determining the need for occupational therapy
Program developers; administrators; legislators; federal, state, and local agencies; and third-party payers in understanding the scope of occupational therapy services
Researchers, occupational therapists, occupational therapy assistants, program evaluators, and policy analysts in this practice area in determining quality and outcome measures for analyzing the effectiveness of occupational therapy interventions
Policymakers, legislators, and organizations in understanding the contribution occupational therapy can make in health promotion, program development, and health care reform to support adults with AD and related major NCDs and their caregivers
Occupational therapy educators in designing appropriate curricula that incorporate the role of occupational therapy with adults with AD and related major NCDs and their caregivers.

Potential Harms

The studies that met the inclusion criteria for the systematic reviews did not explicitly report potential adverse events associated with the interventions evaluated in these studies. If harms were noted, they would have been explicitly reported in the summary of key findings and would have been taken into account in the determination of the recommendations. Before implementing any new intervention with a client, it is always prudent for occupational therapy practitioners to be aware of the potential benefits and harms of the intervention.

Qualifying Statements

Qualifying Statements

- This guideline does not discuss all possible methods of care, and although it does recommend some

specific methods of care, the occupational therapist makes the ultimate judgment regarding the appropriateness of a given intervention in light of a specific person's or group's circumstances and needs and the evidence available to support the intervention.
- This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is sold or distributed with the understanding that the publisher is not engaged in rendering legal, accounting, or other professional service. If legal advice or other expert assistance is required, the services of a competent professional person should be sought.
- It is the objective of the American Occupational Therapy Association to be a forum for free expression and interchange of ideas. The opinions expressed by the contributors to this work are their own and not necessarily those of the American Occupational Therapy Association.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Chart Documentation/Checklists/Forms

Staff Training/Competency Material

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Living with Illness

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

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Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2017

Guideline Developer(s)

American Occupational Therapy Association, Inc. - Professional Association

Source(s) of Funding

This guideline was commissioned, edited and endorsed by the American Occupational Therapy Association (AOTA) without external funding being sought or obtained. The report was entirely supported financially by AOTA and was developed without any involvement of industry.

Guideline Committee

Not stated

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

The authors of this practice guideline have signed a conflict-of-interest statement indicating that they have no conflicts that would bear on this work.

Guideline Status

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This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Electronic copies: Not available at this time.

Print copies: Available for purchase from The American Occupational Therapy Association (AOTA), Inc., 4720 Montgomery Lane, Bethesda, MD 20814, Phone:1-877-404-AOTA (2682), TDD: 800-377-8555, Fax: 301-652-7711. This guideline can also be ordered online at the AOTA Web site .

Availability of Companion Documents

The following is available:

- Occupational therapy practice framework: domain and process. 3rd ed. Bethesda (MD): American Occupational Therapy Association (AOTA); 2014. Available to order from the American Occupational Therapy Association (AOTA) Web site .

In addition, the following are available in the original guideline document:

- Case studies for occupational therapy practice for clients with Alzheimer's disease (AD) at the early, middle, and late stages, and their caregivers
- Sample International Classification of Diseases, 10th Revision (ICD-10) codes
- Selected Current Procedural Terminology (CPT)® codes

A variety of AD resources are available from the AOTA Web site .

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on November 19, 2010. This summary was updated by ECRI Institute on March 29, 2018. The updated information was verified by the guideline developer on May 7, 2018.

This NEATS assessment was completed by ECRI Institute on March 26, 2018. The information was verified by the guideline developer on May 7, 2018.

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